

The Morey Unit Hostage Incident

While there were no escapes or fatalities, the taking of hostages and the seizure of the tower reveal critical – and correctable – flaws in Arizona’s prison system

IN THE EARLY MORNING HOURS of Sunday, January 18, 2004, inmates Ricky K. Wassenaar, serving 26 years in prison, and Steven J. Coy, serving a life sentence, attempted to escape from the Morey Unit of the Lewis Prison Complex located near Buckeye, Arizona, 50 miles southwest of Phoenix.

The Morey Unit, which opened in January 1999, is a cellblock-style facility that houses 840 inmates (designed capacity: 800). The unit houses a diverse population of Level 2, 3 and 4 inmates, including “protective segregation” inmates, i.e., those who are considered dangerous or in personal danger are segregated from the general prison population. The protective segregation population, and the number of inmates serving life sentences (100), at Morey is the largest of any unit in Arizona’s corrections system.

The two inmates subdued the two correctional officers on duty and seized the unit’s tower triggering a 15-day standoff, the longest prison hostage situation in the nation’s history.

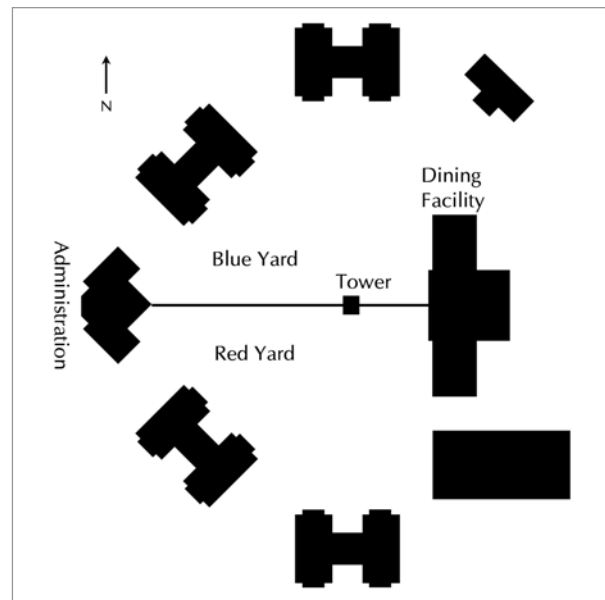
An account of the hostage taking and the negotiations that led to the inmates’ surrender and the safe release of both hostages follows, along with a summary of findings and recommendations aimed at preventing future crises and addressing significant operational, administrative and fiscal issues related to the Arizona Department of Corrections.

THE HOSTAGE TAKING

At 2:30 a.m. on January 18, the 19 members of an inmate kitchen work crew at the Morey Unit were released from their housing units to report for duty at the Morey kitchen.

At approximately 3:15 a.m., the kitchen office was occupied by Correctional Officer Kenneth MARTIN and a female civilian kitchen employee.¹ A member of the kitchen work crew, inmate **Ricky K. Wassenaar**, entered the kitchen office through the open door. Another inmate, **Steven J. Coy**, followed him in, positioning himself in the kitchen office doorway and blocking the only exit.

¹ MARTIN was the only officer assigned on duty in the kitchen, consistent with facility operations and procedures.



Morey Unit, Lewis Prison Complex, Buckeye, Arizona

Wassenaar and Coy seize the kitchen

Wassenaar was armed with a “shank,” a homemade knife-like weapon. Wassenaar approached MARTIN, produced the shank,² and told him that “this is an escape” and “I’ve got nothing to lose.” He ordered MARTIN to remove his uniform shirt (to which MARTIN’s Department of Corrections identification card was attached) and boots. After MARTIN complied, Wassenaar handcuffed MARTIN to a cage in the tool room inside the kitchen office. The other inmate, Coy, who also possessed a shank, brought the female worker into the tool room, ordered her to lie down on her stomach, and tied her hands and feet together with electrical wire.

With MARTIN and the female kitchen worker immobilized, Wassenaar and Coy left the tool room for a short time and then returned. Coy removed

² The two inmates underwent a pat-down search by Correctional Officer John COOPER before they left their housing unit. However, they were not patted down, as required by post order, upon arriving at the kitchen. Further, at the time this report was prepared, it was not known whether or not the two inmates were escorted from their housing unit to the dining facility.

MARTIN's pants and gave them to Wassenaar, who put on MARTIN's uniform, boots and jacket and then shaved off his beard with an electric razor.³ Wassenaar asked MARTIN for the kitchen telephone number, and MARTIN complied.

Wassenaar went to the kitchen work area, where he advised the other inmate kitchen workers of his escape attempt and invited them to join him. When none of them, including the inmates working outside on the loading dock, accepted his invitation, he locked them in the kitchen dry storage area.

At about 4:15 a.m., an hour after he first entered the kitchen office, Wassenaar left the kitchen carrying a 30-inch stainless steel stirring paddle. Coy remained in the kitchen office. Wassenaar walked through the dining area and exited into the Morey Unit's Red Yard, using MARTIN's key to unlock the door. Shortly after Wassenaar left the kitchen area, inmate Coy sexually assaulted the female kitchen worker.

Wassenaar seizes the tower

At about 4:20 a.m., Wassenaar approached the Red Yard gate area that surrounds the 20-foot tower and pressed the access buzzer in the intercom box at the gate. Upstairs in the tower were Correctional Officers Jason N. AUCH and Jane DOE.⁴ AUCH looked at the monitor and, seeing what he believed to be a fellow correctional officer, buzzed the gate open, allowing Wassenaar to enter the tower area. Wassenaar then approached the lower tower door, which, like the entrance gate, was also locked and remotely controlled by AUCH. AUCH buzzed the door open.⁵

AUCH went to the stairs to meet his presumed colleague. Wassenaar kept his head down as he climbed the stairs. As he neared the top he looked up, and AUCH realized that he did not recognize the individual approaching him. Before AUCH could react, Wassenaar struck him with the stirring paddle, fracturing AUCH's orbital bone and temporarily incapacitating him.

Unarmed, Officer DOE attacked Wassenaar, who overpowered DOE and cuffed her hands behind her. Wassenaar forced DOE and Auch to tell him where the



The Lewis Prison Complex. The 800-bed Morey Unit (circled) opened in January 1999.

weapons were, how to operate them, and how to operate the control panel. Wassenaar then ordered AUCH to the lower part of the tower.⁶

Coy remains in the kitchen

At about 4:45 a.m., with the escape attempt still unknown to Morey Unit authorities, Correctional Officer Robert D. CORNETT arrived in the kitchen to relieve MARTIN, 45 minutes ahead of CORNETT's scheduled 5:30 a.m. shift. It struck him as odd that food was on the counters but he did not see any inmate kitchen workers. He saw Coy standing by the "food trap," a pass-through that is used to slide trays between the kitchen and the dining area. Coy's head was in the trap, and he seemed to be talking with someone. CORNETT and Coy had a brief conversation, and CORNETT walked past Coy toward the kitchen office. As CORNETT made his way up the ramp to the kitchen office, Coy approached him from behind, pressed a shank against CORNETT's waist and ordered CORNETT to keep going. CORNETT did so.

Entering the tool room, CORNETT saw the bound female worker face down on the floor and MARTIN handcuffed to the front of the tool rack. Coy took away CORNETT's handcuffs and radio, handcuffed CORNETT to the right side of the tool rack, and went to the dining area. A few minutes later, the kitchen phone rang. Coy returned, picked up the receiver, said, "CO II Martin," and hung up. (It is possible that Wassenaar placed the call from the tower.)

A few minutes later, a call came in on MARTIN's radio from Correctional Officer Coy C. KELLEY,

³ The razor belonged to Wassenaar. At the time this report was prepared, it was not determined how the razor made its way into the kitchen.

⁴ "Jane Doe" is a fictitious name used to protect the female officer's identity.

⁵ The post order for the tower (PO 051) did not require positive identification procedures.

⁶ Tower personnel have access to weapons (an AR-15 assault rifle, a 12-gauge shotgun, and a 37mm launcher), but the weapons were neither loaded nor readily available to the officers.

checking on MARTIN's welfare. Coy held the radio to MARTIN's mouth and, complying with Coy's instruction, MARTIN responded by saying "Code Four" (indicating "situation normal").

KELLEY also radioed the tower requesting clearance to move inmates across the yard. DOE, following Wassenaar's orders, advised KELLEY that the yard was not clear, effectively denying KELLEY's request.

Officer observes "horseplay"

Nevertheless, at about 4:50 a.m., Correctional Officers KELLEY and Elizabeth M. DEBAUGH escorted inmates Jack R. Hudson, Jr., and Michael Sifford from Building Two to early recreation and chow. Their route took them past the tower where Wassenaar held his two captives.

As the officers and inmates walked past the tower on the Blue Yard side of the "spline" (a protected walkway) that separates the two yards, KELLEY looked in the window at the base of the tower. The lights were out, and KELLEY saw two correctional officers wrestling or engaged in what he later termed "horseplay." In fact, what he unknowingly witnessed was Officer AUCH lying handcuffed on the floor of the lower tower.

KELLEY later told investigators that he tried to get into the Blue Yard tower gate but that the gate was not operational, and that he tried to contact the officers in the tower via the speaker box. KELLEY and DEBAUGH proceeded toward the kitchen (Hudson had already continued to the dining area, and Sifford, who did not wish to eat, went directly to his job in the recreational area.).

KELLEY and DEBAUGH entered the dining facility at 4:53 a.m. Hudson placed his personal items on one of the tables and went to the food trap. Hudson knocked on the door of the food trap, and when no food appeared KELLEY and DEBAUGH also knocked. The officers then tried to radio MARTIN, telling him to open the kitchen door. There was no response.

At approximately 4:54 a.m. KELLEY again knocked on the food trap and DEBAUGH sat at the first table in the chow hall. After no response at the food trap, KELLEY joined DEBAUGH at the first table. Inmate Coy opened the food trap and said something that sounded like, "Heidi, Heidi, Ho." KELLEY told Inmate Coy he needed to talk to MARTIN. Inmate Coy said, "Alright," and closed the trap. KELLEY told DEBAUGH he believed he saw something through the tower

window and did not feel right about it. DEBAUGH attempted to contact the tower via her radio and received no response. After waiting a few minutes, KELLEY radioed MARTIN again and received no response.

* * * * *

The chase from the dining facility

Five minutes after arriving at the dining facility, KELLEY and DEBAUGH, who were standing just outside the kitchen door, heard the rattle of keys from the other side of the door.

At approximately 4:59 a.m., CORNETT opened the kitchen door at the direction of Inmate Coy, who was standing behind CORNETT. CORNETT believed he was opening the kitchen door for Inmate Thunderhorse but found KELLEY and DEBAUGH instead. Officer CORNETT later stated that he decided to try to get away from Inmate Coy to get help for the other staff in the kitchen.

CORNETT ran into the dining area past KELLEY and DEBAUGH, yelling "Call IMS, call IMS." (An "Incident Management System" report alerts staff of a situation requiring attention.) Coy followed and pinned KELLEY against a wall. When KELLEY tried to jerk the shank from Coy's hand, Coy slashed KELLEY's face with the shank and pushed him to the floor.

Coy then followed CORNETT, who fled through the exit door onto the Blue Yard. DEBAUGH radioed an alert on her radio advising that an officer was down and an inmate was chasing another officer on the yard. Her report activated the unit's IMS. KELLEY and DEBAUGH then pursued Coy.⁷

The chase took them near the tower, to a point close to the blue gate entrance to the tower area, where Coy was stopped by several officers responding to DEBAUGH's IMS. Coy threatened the officers with his shank. The officers ordered Coy to drop his weapon and lie on the ground. After initially refusing to comply with their orders, Coy finally lay down with his arms spread, but he did not release the shank. As the officers approached him, he got back to his feet and again swung his shank at the officers. A couple of

⁷ Immediately after DeBaugh issued the IMS, a male voice on the radio replied, "Negative, negative, negative." It is possible that the voice belonged to Wassenaar, trying to discourage responses to the IMS. Whether it was Wassenaar or a correctional officer, the "negative" response may have contributed to the belief among some officers that the IMS was a drill instead of an actual alert.

corrections officers attempted to subdue Coy with pepper spray, but, it was ineffective.

Wassenaar foils Coy's capture

Before the officers could take further action, Wassenaar, standing 20 to 25 feet away behind the blue gate near the base of the tower, fired through the blue gate an undetermined number of rounds (most estimates ranged from nine to ten) from an AR-15 rifle toward JONES and the other officers. Seeing what appeared to be a uniformed correctional officer holding the rifle, JONES asked the shooter whom he was firing at. Wassenaar shouted, "You, (*expletive*)."
JONES directed all officers to clear the yard. Coy, standing alone in the yard, went to the Blue tower gate, from where Wassenaar let him into the tower. Wassenaar and Coy were now in control of the tower and of their hostages, AUCH and DOE. Shortly after entering the tower, Coy sexually assaulted Officer DOE.

In all, Wassenaar fired approximately 14 rifle rounds during the early stage of the incident – approximately nine from the lower tower and at least five from the upper tower. While it may seem remarkable that Wassenaar's shots, from relatively close range, failed to hit any human targets, it is likely that firing through the gate restricted his ability to effectively aim the weapon.

As the other officers withdrew to the Administration building, KELLEY, DEBAUGH, JONES and Sgt. Andrew J. KNEIDEL ran to the dining facility, locked the outer door and went to the kitchen. KNEIDEL found MARTIN and the female worker in the kitchen office. The officers also found and performed a head count of the inmates who had been locked in the dry storage area. All officers and inmates were removed from the dining facility by the Tactical Support Unit.

At the Administration building, JONES went into the Deputy Warden's conference room and started to account for his staff. Two officers were missing: AUCH and DOE.

DOC RESPONSE

Captain Michael FORBECK was conducting perimeter checks at the Lewis Complex when he heard the shots fired by Wassenaar. After being briefed on the situation, FORBECK believed there was a risk of the two inmates rushing the Administration area, armed

with weapons stored in the tower, in an attempt to escape. He organized a defense of the Administration area, with shotguns loaded with birdshot. He also contacted the other Lewis units; ordered a Complex-wide shutdown; ordered Tactical Support Unit (TSU) assistance for the Morey Unit; and notified the Buckeye Police Department, the Maricopa County Sheriff's Office, and the local fire department.

At 5:25 a.m. on January 18, approximately 25 minutes after DEBAUGH issued her IMS from the Morey dining facility, Department of Corrections (DOC) Southern Regional Operations Director MEG SAVAGE received a page from the Lewis Complex, advising her of a serious, unspecified inmate disturbance. Within the hour:

- The duty officer at the Lewis Complex was advised of the hostage situation, as was DOC Division Director Jeff HOOD, who, in turn, notified Lewis Complex Warden William GASPAR.
- The DOC Tactical Support Unit (TSU), based at Perryville, was activated and placed on standby.
- DOC contacted the Arizona Department of Public Safety (DPS) to request the assignment of hostage negotiators.

Shortly after 6:30 a.m., Dennis Burke, Chief of Staff to Governor Janet Napolitano, was notified of the incident. He in turn notified the Governor and other key staff members. DOC Director Dora SCHRIRO, who was out of state at the time of the incident, returned to Arizona and arrived at the Command Center at 11:30 a.m. The Command Center had been established earlier in the morning at DOC headquarters in Phoenix.

The DOC Inmate Management System (IMS) policy establishes a command structure to respond to critical incidents. The incident is managed locally by the on-site Incident Commander (IC) and, depending on the seriousness of the situation, also from Central Office by the agency Incident Commander. During the Morey hostage situation, three command centers were established: two on-site command centers (one to manage the events occurring in the tower and another to manage the day-to-day complex operation, complex perimeter security, and coordinate tactical maneuvers occurring at the Lewis Complex Rast Unit), in addition to the agency command center.

At the Lewis Complex, by 7:45 a.m. TSU snipers were positioned on buildings surrounding the tower, and DPS hostage negotiators, operating under DOC authority, and a DPS SWAT team were on site. A Command Post was set up in the Warden's conference room. (By the time the incident was resolved, a total of 30 negotiators had been deployed – 10 of whom actually conducted negotiations – from DPS, DOC, the Phoenix, Tempe and Glendale police departments, the Maricopa County Sheriff's Office, and the FBI.)

Over 16 law enforcement agencies provided support and assistance during the course of the incident:

- DPS deployed over 230 officers, with a core element during the incident of about 75 detectives and officers and surveillance specialists.
- The Maricopa County Sheriff's Office provided over 100 field force personnel.
- The FBI assigned approximately 100 personnel.

One FBI commander noted that at any given time at Lewis there was over 300 years of experience in seeking negotiated and/or tactical solutions.

From the moment they were deployed, the tactical teams were authorized to utilize their use-of-force policies.

Timeline. The following summary chronology and timeline of the 15 days of the hostage situation contains approximate times, and the panel will continue to examine the various accounts and will supplement any significant discrepancies as they are discovered.

Sunday, January 18

7:00 a.m. Wassenaar phones Captain BARBARA SAVAGE, Morey Unit Chief of Security, to advise her that AUCH has a head injury and needs medical attention. Wassenaar wants to trade AUCH for a lieutenant or sergeant. SAVAGE refuses. Wassenaar demands a helicopter and a pizza. He also warns that if either of the inmates is killed, the other will kill the hostage officers.

8:05 a.m. A DPS negotiator makes phone contact with Wassenaar. The call lasts seven minutes.

8:20 a.m. Wassenaar demands that he receive handcuff keys and that he be allowed to talk to Warden Gaspar and Governor Napolitano. He repeats his demand for a helicopter.

8:20-11:20 a.m. Negotiators have various conversations with Wassenaar, in which he backs off from his demand for a helicopter, demands an AM/FM radio, describes the hostages' injuries, and allows officers to speak briefly to one hostage.

11:19 a.m. Negotiators on the phone with Wassenaar play a tape-recorded message from his sister, pleading for him to end the situation peacefully.

11:38 a.m. Negotiators share with Wassenaar the plan to deliver a handcuff key in exchange for bullets.

12:36 p.m. Wassenaar demands to talk to a television news crew.

12:30-5:30 p.m. Various phone conversations occur between negotiators and Wassenaar.

5:25 p.m. A DPS robot delivers an AM/FM radio to the inmates.

Throughout the day, the Special Operations Unit of the Arizona Department of Public Safety developed a series of detailed, comprehensive tactical resolutions of the hostage situation, based on a variety of scenarios.

Evening: Negotiations continue on conditions for delivering a key to the inmates.

Monday, January 19

Negotiations via phone and/or radio continue from time to time throughout the day.

6:52 a.m. DPS robot delivers a radio battery for the two-way radio already in the tower, plus one handcuff key, a radio charger, and cookies.

7:52 a.m. Inmates return the handcuff key along with three shotgun shells and non-lethal rubber ball rounds used for crowd control.

1:08 p.m. DPS robot delivers cigarettes, hygiene supplies, bottled water and styrofoam cups.

1:18 p.m. Inmates turn in wooden, non-lethal projectiles.

3:00 p.m. At the Command Center, Governor Napolitano and key staff members receive their daily briefing from DOC Director SCHIRO, key DOC staff and interagency personnel (Governor's daily briefing) along with periodic phone updates throughout the day and night.

Tuesday, January 20

Negotiations via phone and/or radio continue from time to time throughout the day.

12:30 p.m. Governor's daily briefing.

1:22-1:38 p.m. DPS robot delivers one handcuff key, bottled water, soap, coffee and cigarettes. In return, inmates allow negotiators to visually confirm the correctional officers being held.

9:51 p.m. DPS robot delivers cheeseburgers, french fries, soft drinks, cigarettes and coffee. In return, inmates turn in numerous types of prescription drugs, two hand-made shanks, a canister of Mace and a cartridge for a 37mm firearm.

11:00 p.m. A health and welfare check is conducted with hostages via two-way radio.

Wednesday, January 21

Negotiations via phone and/or radio continue from time to time throughout the day.

8:00 a.m. Governor's daily briefing.

12:20 p.m. DPS robot delivers Tylenol and three small cups. In return, inmates return two pepper spray gas canisters.

12:22 p.m. Inmates fire pepper spray gas into the yard after they discover that a nearby fence had been cut.

7:29 p.m. Negotiators receive voice confirmation of the alertness of both hostages.

Thursday, January 22

Negotiations via phone and/or radio continue from time to time throughout the day.

9:30 a.m. Governor's daily briefing.

10:29 a.m. Wassenaar asks to speak to a television reporter, answering questions the reporter would fax to him.

12:15 p.m. Negotiators give inmates Interstate Compact letters from other states to review.

3:20 p.m. Both correctional officers appear briefly on the roof, allowing for a visual welfare inspection.

9:30 p.m. Governor's daily briefing.

Friday, January 23

Negotiations via phone and/or radio continue from time to time throughout the day.

9:00 a.m. Governor's daily briefing.

4:50 p.m. Wassenaar demands to speak to a reporter on live radio.

8:45 p.m. Negotiators discuss with Wassenaar the terms of releasing one correctional officer.

Saturday, January 24

Negotiations via phone and/or radio continue from time to time throughout the day.

10:00 a.m. Governor's daily briefing.

3:15 p.m. DPS robot delivers roast beef, dried beans, summer sausages, tortillas, potato chips, soft drinks, cheese, tuna, mayonnaise, and candy bars. This represents half of the food the inmates requested. The other half would be delivered after the safe release of an officer.

3:20 p.m. *First hostage release.* The inmates release Correctional Officer AUCH from the tower (negotiators had made several overtures to the inmates to release Officer Doe first). He is examined by medical personnel and interviewed by TSU members before being transported by ground ambulance and helicopter to Good Samaritan Hospital in Phoenix. AUCH was treated for injuries, including an orbital fracture that required surgery. He was also interviewed at the hospital by members of the DOC Criminal Investigation Unit, who were gathering information to support the eventual criminal referral against the two inmates.

3:38 p.m. SWAT team members deliver second half of the food request: cheeseburgers, french fries, pizzas, cigarettes, and cheese.

7:15 p.m. Negotiators hear the voice of Correctional Officer DOE voice during a conversation with Coy, confirming her alertness.

Sunday, January 25

Negotiations via phone and/or radio continue from time to time throughout the day.

Family members of one inmate arrive in Arizona to serve as third-party intermediaries.

10:00 a.m. At the Command Center, Governor Napolitano and key staff members receive their daily briefing from DOC Director SCHRIRO, key DOC staff and interagency personnel.

Monday, January 26

Negotiations via phone and/or radio continue from time to time throughout the day.

10:00 a.m. Governor's daily briefing.

Tuesday, January 27

Negotiations via phone and/or radio continue from time to time throughout the day.

10:00 a.m. Governor's daily briefing.

5:05-5:10 p.m. SWAT team members deliver towels, blankets and washcloths. In return, inmates move DOE to the observation deck, making her visible to negotiators for a welfare check.

5:32 p.m. Wassenaar asks to be interviewed on radio as a term of his release, as confirmation that the State will make good on the terms.

Wednesday, January 28

Negotiations via phone and/or radio continue on and off throughout the day.

Family members of the other inmate arrive in Arizona to assist in negotiations.

9:00 a.m. Governor's daily briefing.

12:28 p.m. SWAT team members deliver hygiene products for the inmates and DOE in return for a health and welfare check of DOE.

2:21 p.m. Negotiators hear DOE in the background of a phone call with Wassenaar, confirming her alertness.

Thursday, January 29

Negotiations via phone and/or radio continue from time to time throughout the day.

9:00 a.m. Governor's daily briefing.

3:40 p.m. SWAT team members deliver cinnamon rolls, tortillas and cigarettes, in return for a health and welfare check of DOE conducted by a paramedic.

10:00 p.m. Governor and key staff meet with Director SCHRIRO and key DOC staff regarding the progress of negotiations, including a demand by Wassenaar to be interviewed on radio. The Governor recommends that the radio interview of Wassenaar not be played live without an agreement by the inmates to surrender and release Officer Doe safely.

Friday, January 30

Negotiations via phone and/or radio continue from time to time throughout the day.

10:00 a.m. Governor's daily briefing.

3:36 p.m. SWAT team members deliver cinnamon rolls, Pedialite, Gatorade and cigarettes, in return for a health and welfare check of DOE.

7:16 p.m. DOE is interviewed by a physician for a health and welfare check.

Saturday, January 31

Negotiations via phone and/or radio continue from time to time throughout the day.

10:00 a.m. Key staff to the Governor receive the daily briefing at the Command Center from Director SCHRIRO and key Corrections staff and interagency personnel.

3:56 p.m. SWAT team members deliver an onion, bread and Gatorade.

5:22 p.m. Wassenaar appears on the observation deck holding a shotgun backwards in his right hand.

7:17 p.m. DOE is interviewed via phone by a physician for a health and welfare update.

8:08 p.m. SWAT team members deliver tuna, Pedialite and cigarettes.

Sunday, February 1

9:20 a.m. A third-party intermediary, an uncle of inmate Coy, is on the phone.

10:04 a.m. Wassenaar identifies the negotiator with whom he wants to deal and discusses surrender demands. Additional demands are made once the designated negotiator is on site.

10:14 a.m. DOE's voice is heard; she says that she is "fine."

11:04 a.m. Cigarettes are delivered to inmates.

11:29 a.m. Inmates make demands:

- Turn on power for bathroom access.
- *Wassenaar*: talk to his sister.
- *Coy*: hear a tape of his ex-wife.
- Property in van
- Paperwork confirming no DOC or county custody for future court proceedings
- Clothing

- Steak, beer and pizza
 - 11:52 a.m.** Governor Napolitano arrives at Central Command.
 - 12:35 p.m.** Negotiators play a tape of Coy's ex-wife.
 - 12:51 p.m.** DOE is observed on the roof of the tower with Wassenaar. She does not leave hatch area.
 - 1:26 p.m.** Call with Wassenaar's sister.
 - 2:04 p.m.** Wassenaar calls to say that the power is not turned on, there will be no contact with DOE, and he will have additional demands in 24 hours. If, by that time, the power is not turned on and the additional demands are not met, there will be no contact for 48 hours, and he will have additional demands.
 - 2:39 p.m.** The power is switched on.
 - 2:46 p.m.** Wassenaar fires 37mm multiple baton rounds (non-lethal).
 - 2:57 p.m.** Wassenaar reports no power.
 - 3:13 p.m.** Two inmate uniforms, including underwear, socks and shoes, and copies of revised paperwork are delivered to the inmates. Wassenaar states that he may have disabled the power in the tower. Steaks, baked potatoes, beer and soft drinks are delivered to the tower.
 - 3:39 p.m.** DOC Director SCHRIRO gives the Governor a status report.
 - 3:41 p.m.** A key is delivered to the inmates to allow them inmates to access the first floor to use the bathroom and to clear obstacles and traps to facilitate opening the door and the exit of the inmates and hostage.
 - 3:47-4:18 p.m.** The key is determined to be unusable, and a second key is delivered.
 - 4:25 p.m.** Coy is seen at the hatch.
 - 4:39 p.m.** Governor Napolitano calls for an update.
 - 5:16 p.m.** Contact is initiated to discuss specifics of the surrender process. Coy says to call back.
 - 5:19 p.m.** Governor returns to Central Command.
 - 5:31 p.m.** Contact is initiated to discuss specifics of the surrender process. Coy says to call back.
 - 5:45 p.m.** Contact is initiated to discuss specifics of the surrender process. Coy says to call back.
 - 5:52 p.m.** Wassenaar calls. There is discussion about the specifics of exiting the tower.
 - 6:17 p.m.** Wassenaar appears on the roof in an orange uniform, signifying that the door is clear for opening by the tactical team.
 - 6:20 p.m.** The tactical team approaches the tower, opens the door and props it open with a sandbag. The team then retreats approximately 10 yards.
 - 6:25 p.m.** *Hostage situation comes to an end.* Wassenaar walks out with his hands up. He complies with the order to turn around and lay on the ground and is restrained. DOE exits the tower next; she is recovered by a tactical team and removed to the Administration building and an awaiting ambulance. Coy exits the tower and is taken into custody and restrained.
 - 6:32-7:08 p.m.** DOE is examined and treated in the ambulance. She is then flown by helicopter to Good Samaritan Hospital in Phoenix, where she is treated for injuries sustained during the hostage incident, interviewed by DOC Criminal Investigation Unit (CIU) investigators, and reunited with her family.
 - 6:51 p.m.** Governor Napolitano and Director SCHRIRO depart the Lewis Complex for Good Samaritan Hospital.
 - 7:34 p.m.** Wassenaar and Coy are taken to the Morey Unit's Blue side visitation strip area/non-contact visitation area, where they are photographed by DOC CIU investigators, strip-searched by Bureau of Prison (BOP) personnel, and provided with BOP jumpsuits. Their clothing and other evidence seized from the inmates are placed in containers and maintained by a CIU special investigator.
- Medical staff check the inmates' vital signs prior to transportation to the federal corrections institution in Phoenix, where they are isolated from each other.
- Wassenaar and Coy are served with search warrants for personal characteristics by a DOC criminal investigator. The search warrant is executed by SANE (Sexual Assault Nurse Examiner) staff from Scottsdale Health Care, who collect the sexual assault protocol as directed by the search warrant.
- Wassenaar and Coy are advised of their Miranda rights. Wassenaar invokes his right to counsel, and Coy declines to be questioned.

FINDINGS AND RECOMMENDATIONS

Governor Napolitano's February 10, 2004, action plan for investigating the incident at the Morey Unit included the appointment of an Administrative Review Panel made up of law enforcement and corrections professionals to: (a) reconstruct the sequence of events leading up to the inmates' seizure of the Morey Unit tower, (b) identify issues that directly or indirectly contributed to the incident or could give rise to similar incidents, and (c) recommend practices to improve security and staff safety.

The Administrative Review Panel was comprised of:

- ROBERTO VILLASEÑOR, Assistant Chief, Tucson Police Department;
- JOHN PHELPS, Deputy Director, Arizona Office of Homeland Security; and
- MICHAEL SMARIK, Division Director, Support Services, Arizona Department of Corrections.

The Administrative Review Panel consulted with the following subject matter experts throughout the review process: Lt. John Stamatopoulos, SWAT and Bomb Commander, Tucson Police Department; Thomas McHugh, Administrator, Criminal Investigations Bureau, Arizona Department of Corrections; and Greg Lauchner, Administrator, Special Services Bureau, Arizona Department of Corrections.

Many of that panel's recommendations are incorporated into this section, and the Blue Ribbon Panel acknowledges, with deep gratitude, the painstaking and professional manner in which the Administrative Review Panel fulfilled its mission.

Contents. This preliminary report's findings and 68 recommendations are presented in an order that parallels the chronology of the attempted escape and hostage taking. The issues discussed are:

- A. Inmate Security (*page 9*)
- B. Yard Security (*page 10*)
- C. Kitchen Security and Procedures (*page 10*)
- D. Tower Security, Procedures and Usage (*page 11*)
- E. Defensive Tactics, Techniques and Procedures (*page 12*)
- F. Communications (*page 12*)
- G. Individual and Unit Response (*page 12*)
- H. Inter-Agency Delivery of Tactical, Intelligence Gathering and Negotiation Activities (*page 13*)

- I. Resolution of the Hostage Situation (*page 13*)
- J. Administrative, Policy and Budget Issues (*page 14*)

A. Inmate Security

Lethal weapons in the possession of inmates constituted a leading causative factor in the hostage situation.

Finding: Inmates were searched upon departure from their housing unit, but the kitchen security post order requiring a pat-down search of the inmate kitchen crew upon arrival was not followed. This provided an opportunity for inmates to retrieve weapons or other contraband secreted in the yard and to go undetected at the kitchen.⁸

Finding: Officers conducted hurried and less than adequate pat-down searches of Wassenaar, Coy and the other members of the inmate kitchen crew. The panel concluded from other officer statements and indicators that the quality of this pat-down search was not unusual.

Finding: Same-sex pat-down searches are preferable but not mandated.

Finding: Although the panel could not determine how the shanks in this incident were made or brought into the dining facility, it is clear that without their use Wassenaar and Coy's effectiveness would have been greatly reduced.

RECOMMENDATIONS

1. Review and enforce search procedures upon arrival at the kitchen. Determine where other gaps in search coverage may exist that would provide inmates opportunities to pick up contraband and weapons as they transit areas.
2. DOC should continue to practice cross-gender pat-down searches when necessary.
3. Establish a Special Contraband Squad (SCS), either statewide or with one squad in each of the two regions, the sole function of which would be to conduct random, unannounced searches of prison units for contraband and weapons. SCS searches would be supported by the latest available detection equipment technology and trained canines. The SCS would be specially

⁸ It is possible that the shanks were hidden in the kitchen. Although records indicate that a contraband search of the kitchen occurred at 1:00 a.m., there is no evidence as to the quality and extent of the search. The inmates may have had their weapons when they left the housing unit (which would indicate that the pat-down was insufficient), or the weapons were in the yard, or the weapons were in the kitchen – possibly implicating an absent civilian kitchen worker.

trained in the latest detection methods, uses of equipment, and methods employed by inmates to secret contraband. The selected unit would be placed on lockdown as soon as the SCS arrives onsite, and the SCS would be accompanied by unit mid-level and base-level supervisory staff during the search. All areas of the selected unit would be searched during the lockdown. No shift change or movement of inmates would be permitted during the search. Only those officials with an absolute need to know would be informed of the pending search and then only at the last minute.

4. All incoming staff, contractors and visitors and their possessions should be scanned and/or searched for contraband prior to gaining access to the unit. If contraband is detected, discretionary progressive punitive measures should be imposed, ranging from a warning to dismissal and/or prosecution.
5. All post orders should be reviewed to assure that explicit direction is given relative to inmate search requirements prior to movement within the unit perimeter and when the inmate returns from travel outside the unit. The review should focus on minimizing the ability of inmates to access hidden contraband prior to entering less secure areas. Consideration should be given to changing search methods on a random rotational basis to disrupt predictability. Search requirements should be strictly enforced by supervisory personnel, including personal unannounced oversight.
6. Shanks are a continual and recurring problem in the corrections world. Current procedures and methods for preventing the manufacture and uncovering the concealment of fabricated weapons must be emphasized and regularly tested. Additionally, DOC should consider whether state-of-the-art detection systems not already employed could be brought to bear in this area. Technology notwithstanding, the last line of defense for the detection of fabricated weapons is the individual vigilance and competence of correctional officers and their leaders.
7. DOC should review protocols for unit contraband searches to emphasize thoroughness, unpredictability and consistency.

B. Yard Security

Finding: Inmates may hide weapons or contraband under gravel.

RECOMMENDATION

8. Consider removing gravel or other soft materials from the yards and replacing them with a more stable ground cover that is less likely to provide cover for weapons or contraband.

C. Kitchen Security and Procedures

The following factors created conditions in the kitchen area that significantly compromised security and, thus, contributed to the incident:

Finding: The inmates were too familiar with officer routines.

Finding: Kitchen duty was inappropriate for the two violent offenders.

Finding: Kitchen office door was left unsecure. Open access to the kitchen provided the opportunity for inmates to take control of unit personnel, communications systems and weapons.

Finding: Delivery of kitchen utensils required hand-to-hand delivery via open kitchen office door. The doors to the kitchen and tool room must be opened to pass kitchen tools to inmates. It became impractical and inconvenient to repeatedly open and lock those doors when the kitchen was active.

Finding: Kitchen post required only one officer. Inmates could easily overpower the solitary officer on duty during the graveyard shift, unobserved by the rest of the unit. When the incident began, Correctional Officer MARTIN by himself was in charge of 19 inmates.

Finding: The kitchen area was unmonitored. Although the dining halls outside the kitchen areas were monitored by video cameras, there were no audio or video monitors in the kitchen area.

Finding: A contract kitchen worker was absent without explanation on the morning of the incident and has refused to cooperate with the investigation

RECOMMENDATIONS

9. Rotate inmates' work assignments and schedules so that they have less opportunity to familiarize themselves with officers' routines and work habits.
10. Dangerous inmates should be limited in their work assignments, and inmates with life or long-term sentences should be strictly limited in their range of job duties.
11. DOC or other appropriate authorities should interview the contracted kitchen staffers who worked at the Morey Kitchen for at least six

Adult Prison Population

- There are approximately 32,000 inmates in the DOC system.
- There are 6,146 CO IIs.

months preceding the hostage incident. Any potential complicity should be thoroughly investigated.

12. The door to the Kitchen Office should remain locked at all times unless it is opened to allow a correctional officer to enter or exit. A standoff distance should be established in the kitchen that an inmate cannot cross. If this area is occupied, the door should remain locked until it is clear (e.g., a line painted red at the entrance to the ramp that leads up to the office).
13. DOC should consider methods that will eliminate the need to pass kitchen utensils in a hand-to-hand manner. For example, a pass-through security drawer to deliver utensils, operated by the kitchen officer, could be installed.
14. Utensils and tools should be secured. This action may be less necessary at low-level units, but the administration at such units should utilize caution before implementing such a policy.
15. Two correctional officers should be posted in the kitchen area at all times.
16. Place high-resolution video cameras in the kitchen area to provide visibility of inmate activities from the facility's main control area. Camera feed should be live-monitored instead of merely being recorded for after-the-fact review.

D. Tower Security, Procedures and Usage

The following factors created conditions regarding access to the central tower that significantly compromised security:

Finding: Excessive tower access points exist. Multiple entryways into the tower provided inmates opportunities for access. (Wassenaar entered from the Red Yard, Coy from the Blue.)

Finding: There were no established positive identification protocols.

Finding: The tower was subject to multiple uses for which it was not intended. Uses included storage of a variety of items, including medicine for distribution to inmates. The panel believes that this offered inmates opportunities to gather intelligence about the tower,

such as design, and layout, the function of the spline gates and doors, etc.

Finding: Inmate movements were not observed from the tower. There is no evidence to indicate that the movement of Wassenaar, Coy and other kitchen crew inmates was observed by officers as they moved from their housing units to the kitchen. Wassenaar's exit from the kitchen and movement to the tower was also unobserved. Such lack of observation provided opportunities for inmates to circumvent security and reduced the unit's situational awareness.

Finding: Tower post duties were inadequately defined. Post order duties lacked specificity and did not clearly require observation of the yard at all times, particularly when inmates were present.

Finding: Post order instructions regarding weapons deployment were not followed. Officer Doe reported that she could not reach the AR-15 to defend herself from Wassenaar. Even if she had reached it, the weapon was unloaded as directed by unit supervisors.

RECOMMENDATIONS

17. DOC should review the need to staff the central towers at Lewis and other architecturally similar institutions in the DOC system.
Recommendations 17-26 should be considered if a decision to staff the central tower is continued:
18. Non-removable listening devices should be installed in the tower.
19. DOC should improve cameras, camera location and lighting at all controlled entry points to the tower to allow for positive identification of persons seeking entry.
20. The tower should be accessed only at one entry point. The panel recommends limiting access from the Administration building spline. Lewis Post Order 051 should be revised to include specific instructions on entry and exit from the tower. The practice of "buzzing in" people from the upper floors or not confirming identification on a face-to-face basis should be considered a serious breach of performance standards.
21. On the longer term, DOC should review the operational and tactical merits of maintaining lethal and less-than-lethal weapons and munitions in a central tower location within a secured perimeter.
22. DOC should require post-specific training pertaining to the tower.
23. Only shift-assigned tower staff, tower relief staff and shift supervisors should be allowed to access

the tower without the shift commander's direct approval.

24. DOC should review tower design and make modifications necessary to allow full operations from the second level.
25. DOC should review, modify as needed, and strictly enforce tower post orders to ensure consistency of tower operation, with emphasis on security.
26. The tower should always be staffed with two qualified officers, both armed with sidearms at all times. When granting access to the tower, one officer should remain at the observation level while the second officer acquires positive identification.
27. Tower and munitions should be kept at "at-the-ready" at all times when the tower is staffed. Weapons stands are probably the most effective way of keeping weapons ready accessible.

E. Defensive Tactics, Techniques and Procedures

Finding: Correctional officers were unable to defend themselves or others using individual or small unit defensive tactics. This was a major factor in the ability of the inmates to subdue officers, escape capture and seize the tower.

Finding: Use of OC pepper spray canisters was ineffective. Studies have shown that it is nearly impossible to use pepper spray to thwart an attack by an individual armed with an edged weapon, where the attacker is closer than 21 feet from the intended victim. Further, an OC canister is an ineffective tool against a knife because it is not possible to get close enough to produce the desired results.

Finding: Post Order #051 is inconsistent with Department Order 804 - Inmate Behavior Control. Six sections specify when an officer is authorized to use lethal force. Section 1.2.6 is the only section that discusses serious bodily harm;⁹ all other authorized uses of lethal force have to be predicated on a belief that an inmate is attempting to use lethal force or attempting escape. Unfortunately, "serious bodily harm" is not contained in PO 051. Section 051.06.8.1 reads, "Deadly force is justified when it is immediately necessary to protect any person from attempted use of unlawful deadly physical force by another and to prevent an escape." As the "ultimate safeguard," the tower officer and all staff must have confidence and

trust in each other. They must trust that, if they are attacked by an inmate posing a threat and showing intent of serious bodily harm, lethal force will be authorized.

RECOMMENDATIONS

28. Modify PO #051.06.8.1 to include Department Order 804.07.1.2.6. Reinforce the knowledge and understanding of that order in training and exercises.
29. Consider adding other, more effective less-than-lethal weapons for day-to-day operations of correctional officers. This consideration should be to integrate such systems into standard operations rather than limiting those capabilities to special situations.
30. All DOC employees and contractors who directly interface with inmates should receive realistic training in self-defense tactics. Such training should be integrated into in-services refresher training programs.
31. Correctional officers should receive enhanced and realistic training in hand-to-hand, weapons, and small-unit defensive tactics. Such training should be integrated into in-services training. Consider requiring minimum qualification standards and recognition/certification programs for advanced proficiency, which would be considered in assignment decisions and operational planning.

F. Communications

Finding: Monitoring throughout the facility does not appear to take full advantage of technology.

Finding: Officers have little ability to covertly request assistance. After they were taken hostage, Officers MARTIN and DOE were forced to respond over unit communications systems to other officers in the facility. Their forced responses falsely indicated that they were secure.

RECOMMENDATIONS

32. DOC should review current communication systems with the emphasis on improving performance. Such review should include reducing dead areas, the benefits of encryption, specialized distress capability, battery dependency, and radio durability.
33. DOC should review units' audio and visual monitoring capabilities and consider retrofitting key facilities with embedded sensors and cameras for regular monitoring of activities.

⁹ "... when it is necessary to prevent an inmate from taking another person hostage or causing serious bodily harm to another person ..."

34. Establish a simple distress signal. Evidence suggests that inmates had gathered intelligence on communication procedures and radio codes. A distress signal would therefore need to sound natural and part of a routine response.
35. DOC should also consider investment in personnel monitoring – “man down” or personal alarm – systems.

G. Individual and Unit Response

Finding: Correctional officers lacked situational awareness. The collective lack of awareness regarding this incident not only affected facility security but exposed officers and facility employees to harm.

Finding: There was ineffective response to an armed inmate in the dining area. When Coy exited the kitchen, there were three officers in the dining area. Officers were not equipped or trained to respond effectively as a team to an armed inmate.

Finding: Many officers failed to respond appropriately to IMS calls. The frequency and manner in which IMS simulations occur led to complacency on the part of most officers on duty at the time of this incident. No codes or practices exist to differentiate between an IMS simulation and actual occurrence.

Finding: Many officers in the Morey Unit have less than a year in uniform.

RECOMMENDATIONS

36. Training (IMS simulations) should not occur during duty hours. Occasionally, if supervisors want to test the performance of their staff on a fire drill or lockdown, on-unit training would be recommended. However, training designed to test and evaluate tactical responses, arrest procedures, use of lethal and less-than-lethal force, and even medical response should never be conducted where it could compromise security or be viewed by inmates. Exceptions may be made only with the written approval of the DOC Director. Training should be as realistic as possible, but there should be no doubt in any staff member’s mind about whether a situation is a simulation or a real event. This is accomplished by never blending duty assignments with training scenarios.
37. DOC sergeants must be recognized as a focal point of the agency and given the power to address issues immediately. The first-line supervisor is the unit’s eyes and ears and can identify training deficiencies, operational issues and performance problems. The sergeant should

be highly visible as he or she moves about the unit and conducts surprise inspections at various posts; this would help to eliminate reported unauthorized visits to the tower and the leaving of assigned posts. It would also help address the allegations of officers bringing food into the unit from outside the prison, propping doors open, conducting quick and ineffective pat searches, etc.

38. On-duty training opportunities should be explored, such as daily training items that are presented and discussed at briefings or when supervisors conduct inspections. These training items can consist of incident scenarios that are read or presented, requiring officers to discuss their answers with their supervisors.

H. Inter-Agency Delivery of Tactical, Intelligence Gathering and Negotiation Activities

Finding: State and local law enforcement agencies regularly convene to practice tactical maneuvers. DOC does not routinely participate in those activities, nor do those activities regularly occur on the grounds of a State prison complex.

Finding: State and local law enforcement agencies do not regularly convene to practice negotiations. DOC does not participate in those activities when they do occur, nor do those activities occur on the grounds of a State prison complex.

Finding: DOC and State and local law enforcement agencies do not know enough about State correctional facilities’ amenability to intelligence gathering technologies and tactical maneuvers.

RECOMMENDATIONS

39. DOC and State and local law enforcement agencies should regularly convene to practice tactical maneuvers. Some scenarios should be conducted regularly on the grounds of a State prison complex.
40. DOC and State and local law enforcement agencies should regularly convene to practice negotiations.
41. DOC, with assistance from federal, State and local law enforcement agencies, should evaluate DOC’s physical structures to identify in advance of untoward events their amenability to intelligence collection and tactical maneuvers. This information should be kept onsite at each institution and updated regularly.

Tactical Rules of Engagement For Double Hostage Situations

1. Both inmates on roof, 100% positive identification, clear shot: Green light, shoot to kill.
2. One inmate with both hostages on roof, 100% positive identification, clear shot: Green light, shoot to kill.
3. Inmate, 100% positive identification, appears with lethal force directed at hostage(s): Green light, shoot to kill.
4. Inmate appears with lethal force, non-threatening: Red light, do not shoot.
5. Inmate appears on roof with one hostage: Red light, do not shoot.

In options 2 and 3, activation will also initiate the assault on

I. Resolution of the Hostage Situation

Finding: It is the policy of DOC that there are no negotiations with hostage takers. Despite that policy, in the situation at the Morey Unit there were ongoing negotiations during the entire 15 days.

Finding: With regard to the tactical response, the panel received testimony from correctional employees (who were not part of the tactical teams) that they had heard of opportunities to use lethal force toward the two inmates during the standoff, but they were foregone due to alleged counter-instructions from superiors. This testimony was later refuted by numerous members of tactical teams, including both lead commanders of the tactical operation, DPS Colonel Norm Beasley and Maricopa County Sheriff's Office Assistant Chief Jesse Locksa. Indeed, Beasley categorically stated to the panel, "There was never an opportunity to tactically resolve this situation through sniper fire."

Finding: DOC's decision to transfer the inmates out of their system is a common corrections management practice after hostage situations. This practice preserves the integrity of the statewide security system; diminishes the inmates' status in the prisoner society; and reduces potential legal liability. Indeed, DOC houses approximately 100 inmates from other state systems, including several as a result of the Lucasville, Ohio, prison hostage incident in the early 1990s.

RECOMMENDATIONS

42. DOC should review the communications that occurred between negotiators and tactical staff

relating to the cutting of the fence at the base of the Morey tower.

43. Due to the uniqueness of the situation and the virtually impenetrable characteristics of the tower, the lack of acceptable tactical solutions available to authorities made negotiations a practical necessity. To be consistent with other law enforcement and correctional agencies, DOC should eliminate its non-negotiation policy.
44. The use-of-force provisions of the rules of engagement (*above*) were appropriate and should be applied to future situations where their use may be applicable.¹⁰ At the Morey Unit, circumstances did not permit the exercise of those provisions.

J. Administrative, Policy and Budget Issues

*Finding: Inmate classification.*¹¹ The DOC inmate classification system is cumbersome and unreliable and has not been evaluated since the 1980s. Other correctional jurisdictions have developed more effective and efficient systems.

RECOMMENDATIONS

45. DOC should assess its inmate classification needs and seek national assistance in the enhancement, overhaul or replacement of its present system. DOC's policies and procedures regarding protective segregation should be reviewed as part of the assessment.
46. Public and Institutional (P&I) scores should be more closely examined, and the officers who work with an inmate should have meaningful input into that inmate's score.
47. Classification scores should be less vulnerable to override.
48. Create a system that better ensures that more dangerous inmates do not work in sensitive areas.

* * * * *

Finding: Inmate Assessment, Programming and Reentry. Good prison security and management require more than just good correctional officers; it takes a team approach.

¹⁰ After the first hostage was released, the tactical rules of engagement were revised to reflect the change of circumstances.

¹¹ Classification determines an inmate's housing situation, work assignments, recreational opportunities and supervision levels.

RECOMMENDATION

49. DOC should evaluate the methods by which, upon intake, it assesses offenders' criminogenic and programming needs. It should further endeavor to provide appropriate levels of programming in areas such as mental health treatment, drug treatment and education. Programming should also be enhanced to assist offenders in successfully reentering society upon release from prison.

* * * * *

*Finding: **Training.*** Testimony received from DOC employees strongly suggests that uniformed and civilian staff are undertrained and, in some cases, untrained in many areas, some critical.

RECOMMENDATIONS

50. As appropriate to carry out their responsibilities and ensure their personal safety, officers, supervisors and civilian employees should receive continuing education and practical training in areas that include, but are not limited to, the following: self defense, weapons training, hostage situations, post-specific training, weapons and contraband searches, Fire Arms Training Simulator (FATS), cross-training with other law enforcement agencies, Arizona Peace Officer Standards & Training (POST) certification, and structured on-the-job training and mentoring.
51. At the Correctional Officer Training Academy (COTA), cadets should receive one full additional week of training dedicated to self-defense and receive additional training in hostage situations, rape prevention, and weapons.
52. Standards for admission to and graduation from COTA must not be compromised in response to vacancy rates or other temporary situations.
53. New COTA graduates should enter service as a CO I. After a defined probationary period, and additional on-the-job training, they should become eligible for promotion to CO II.
54. DOC should implement a comprehensive and systematic "Back to Basics" (B2B) program to ensure that core elements of security are being adhered to across the board. The B2B initiative should be designed to enable every prison to review security in regard to layout, personnel, habits, traditions, training and other issues. B2B should include interviews with line staff to find out how they actually do the job and how they should do the job, so that it can be determined whether security is being compromised by not

Correctional Officer Turnover

A DOC SURVEY covering the two-year period from November 2001 through October 2003 reveals the following:

- There are 6,146 CO IIs in the DOC system.
- There were 1,721 CO II resignations during the survey period.
- Not adjusting for multiple resignations from the same position, the two-year turnover rate was approximately 28%.
- 570 of the 1,721 resignations (33%) occurred during the employees' first 12 months on the job.
- 1,008 of the resignations (58%) occurred during the first two years.
- 1,268 of the resignations (73%) occurred during the first three years.
- Only one in four CO IIs had more than three years of experience.

Source: Governor's Office of Strategic Planning & Budgeting

adhering to post orders, or whether officers have devised a better way to get desired results.

55. Civilian employees should receive training to help them understand and function safely in a prison work environment.

* * * * *

*Finding: **Experience and Staffing.*** Inexperienced officers, when placed together in high-risk settings, are more likely to fail in the performance of their core functions than if they are teamed with more experienced officers.

Finding: Correctional facilities are understaffed. Correctional officer positions remain unfilled while the prison population grows every month. At the Lewis prison complex, of which the Morey Unit is a part, about 200 (or 19%) of the 1,029 officer positions are vacant, on some days forcing management to scramble to provide the minimum coverage. Of the 800-plus positions that are filled, half of the officers have two years or less of service (including their seven weeks of training at COTA). In many instances, junior officers are led by other junior officers who have been prematurely promoted in order to meet pressing needs. At the time of the hostage taking, 14 of the 20 officers on duty were hired in 2003 (i.e., had one year or less of experience).

RECOMMENDATIONS

56. DOC should formalize the blending of experienced and inexperienced officers, leading to “mentor/student” bonding that can enhance long-term officer success and retention. The mentoring program should be formalized as a structured, agency-wide Correctional Training Officer (CTO) program that features formal training and rewards for experienced officers, at all levels and positions, who act as mentors.
57. Additional staffing is necessary for all assignments within DOC in order to combat fatigue and burn-out and to foster proper employee in-service training needs. Current “bare bones” staffing does not allow for the remediation of any of the above.

* * * * *

*Finding: **Pay, Recruitment and Retention.*** DOC officers are underpaid, both in absolute terms and in comparison to the pay scales of other jurisdictions. The DOC pay scale leads to family hardships, low morale and high attrition. A sergeant with ten years of experience testified at a public forum that he would be eligible for Food Stamps and AHCCCS benefits if his annual income were only \$933 less. He also suffered a pay cut when he was promoted (most sergeants are paid less than the officers they supervise).

Finding: The Nevada Department of Corrections, which offers higher officer pay, recently set up a recruiting station at a Circle K near the COTA facility outside of Tucson to lure academy graduates. After being trained at a cost to Arizona taxpayers, half of the class went to work for the State of Nevada.

Finding: There is pay inequity between new recruits and experienced officers. Elimination of the “Correctional Officer I” position during the previous Administration created a situation in which a recent academy graduate enters service as a CO II, perhaps earning as much as a veteran officer at the same grade.

Finding: Standards have been lowered. Qualifications for sergeant have been diminished in recent years in order to fill vacancies at that level.

RECOMMENDATIONS

58. DOC should undertake a comprehensive analysis of its pay scale, including a comparison with the pay scales of federal, county and municipal correctional entities in Arizona and of surrounding states.
59. DOC should consider the reinstatement of merit increases and longevity pay.

Starting Compensation for Correctional Officers

	Base Pay	Hiring Bonus ¹	Incentive Bonus ²	Total
DOC	\$24,950	\$2,600	\$2,495	\$30,045
Maricopa County	\$31,000	\$0	\$0	\$31,000

¹Generally expires after the second year of service.

²Available only to CO IIs at Lewis, Florence and Eyman.

60. DOC should restore the CO I position, reexamine the qualifications for Sergeant, and undertake a comprehensive review of DOC’s promotional policies to ensure they are based on merit and performance, not “good old boy” relationships.
61. Pay must be commensurate with experience and merit, and any promotion should result in higher pay.
62. DOC should consider ways of communicating to the public the difficulty of and danger associated with correctional service.
63. Survivors of officers killed in the line of duty should receive benefits comparable to the families of police officers and fire fighters.

* * * * *

*Finding: **Professionalism.*** At the time of the hostage situation, the Morey unit suffered from complacency and a general lack of professionalism. While most staff performed admirably during the incident, there were many administrative errors in the preceding months and years. During the panel’s investigation it became evident that numerous deficiencies in supervision and performance contributed to the hostage situation.

RECOMMENDATIONS

64. The DOC Director should utilize all available information to determine what, if any, disciplinary action or change of assignment is appropriate for those staff involved.
65. A system-wide review should take place to determine whether this problem is pervasive in the system and, if so, to identify and implement steps that could remedy the problem.

* * * * *

*Finding: **Operational audits.*** In 2000, DOC discontinued the practice of conducting comprehensive operational audits of prison facilities.

RECOMMENDATION

66. Operational audits should be reinstated to help ensure effective management of prison facilities.

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*Finding: **Staff/Inmate Communication.*** Good staff/inmate communication is important to maintaining good prison security and operations.

RECOMMENDATIONS

67. DOC is encouraged to take steps to review current policies, practices and protocols that promote indirect, as opposed to direct, supervision of offenders and that inhibit good communication between officers and offenders.
68. DOC should consider piloting a prison management system, such as “Unit Management,” at a prison that is architecturally and operationally receptive to such a concept.

* * * * *

*Finding: **Sentencing.*** The DOC system suffers from overcrowding. In the last year, DOC has set the highest records of overcapacity and the Lewis facility has regularly housed inmates in excess of its design capacity.

RECOMMENDATION

69. The State of Arizona should undertake a comprehensive review of its sentencing statutes.

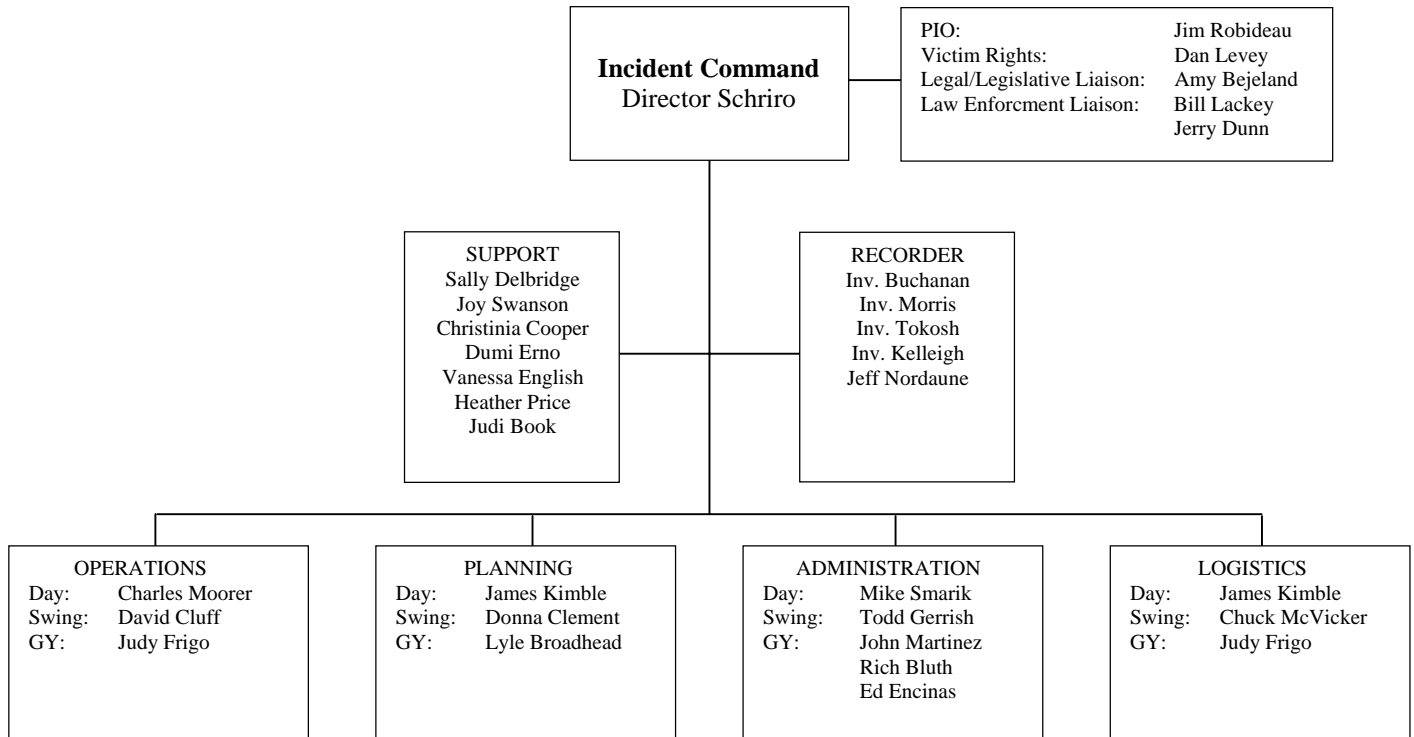
CONCLUSION

The hostage-taking incident that occurred at the Morey Unit was a tragic event that resulted in serious physical and emotional injury to correctional officers and facility employees. Like other prison crisis situations in Arizona and elsewhere, it demonstrated the incredible dangers and challenges faced by corrections professionals every day.

The two inmates exploited a series of small but critical gaps in security that were further compounded by institutional complacency and a collective lack of situational awareness. Once faced with the reality of the deadly situation inside the tower – the facility’s most secure and impenetrable feature – correctional officers and their leaders responded quickly and effectively to establish the conditions that ultimately led to the successful release of hostages and recapture of inmates without loss of life.

The lessons learned from this incident revalidate the necessity of adequately and properly resourcing corrections operations. Of equal importance is the need to acquire the essential qualities of a competent and proud organization. Such qualities can be obtained only by investing in the people that dedicate themselves to the corrections mission. They must be well trained and well led; and recognized often and fairly compensated. Although one can never guarantee that such an incident will not occur again, the panel believes that much can be done to reduce that risk. ■

DOC Central Office United Command Structure



LEWIS UNIFIED COMMAND STRUCTURE

